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ABSTRACT

This paper provides an overview to help trustees of higher education institutions learn how to form a collective knowledge base and ask penetrating questions about academic health center (AHC) governance practices, which vary by institution. The advice offered is addressed particularly to governing board members, chief executive officers, and administrators who need a framework for understanding their responsibilities as they attempt to balance the academic and revenue-producing missions. The paper summarizes efforts by participants at a June 2003 symposium, organized by the Association of Governing Boards of Universities and Colleges (AGB), the Association of Academic Health Centers, and the Association of American Medical Colleges, that considered: (1) what university governing boards have learned about the crisis in academic medicine and its implications for institutional governance; (2) what university governing boards need to know in order to fulfill their governance responsibilities more effectively; (3) how a university can ensure appropriate governance oversight of its AHC; and (4) what the Association of Governing Boards of Universities and Colleges (AGB) can do to help meet the needs of governing boards with responsibilities for AHCs. (SLD)

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Academic Health Center Governance and the Responsibilities of University Boards and Chief Executives (Report of a Symposium)

Gregory R. Wegner

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Association of Governing Boards of Universities and Colleges

OCCASIONAL PAPER SERIES

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N° 50

ACADEMIC HEALTH CENTER GOVERNANCE AND THE RESPONSIBILITIES OF UNIVERSITY BOARDS AND CHIEF EXECUTIVES

(*REPORT OF A SYMPOSIUM*)

BY GREGORY R. WEGNER

In the United States there are about 143 academic health centers (AHC)—125 anchored by allopathic medical schools, and another 18 anchored by osteopathic medical schools. Some 104 AHCs are university-based—70 public and 34 private—and, therefore, fall within the purview of a university or system governing board.

These centers are integrally related to their host institutions; they are large, complex organizations; and many account for much more than half the budget of their parent university.

The trifold mission of an AHC is to educate future health professionals, conduct biomedical research, and provide medical care to a local region. AHCs typically comprise a medical school, several other health professional schools and programs, and owned or affiliated teaching hospitals and other clinical operations, each giving rise to different organizational cultures that require different management systems and accountability measures.

AHCs epitomize the kind of complexity that increasingly is characteristic of universities themselves. While fulfilling an academic mission, these centers must navigate the turbulent domain of health-care markets, regulation, and third-party payers. AHCs and their home universities confront a growing need to manage effectively, to be attentive to both the challenges and opportunities that accompany change, to be entrepreneurial, and to take calculated risks in the face of uncertainty.

Gregory R. Wegner is director of program development for the Great Lakes Colleges Association and managing editor of Policy Perspectives, *a publication of the Higher Education Roundable.*

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EXECUTIVE SUMMARY

At most American institutions in which the university or system governing board has direct authority over an academic health center (AHC), trustees probably lack a detailed knowledge of the modern health-care system. Yet because they bear fiduciary responsibility for the university and its AHC, the board and executive leadership must be concerned with the AHC's financial condition and academic vitality.

The very size of the AHC's budget and the volatility of the health-care environment are sources of continuing concern. The board and chief executive must understand the circumstances of an AHC well enough to exercise responsible judgment on many complex issues that affect the university's financial integrity.

This paper provides an overview to help trustees learn how to form a collective knowledge base and ask penetrating questions about AHC governance practices, which vary by institution. The advice offered here is addressed particularly to governing board members, chief executive officers, and administrators who need a framework for understanding their responsibilities as they strive to balance the academic and the revenue-producing missions.

This paper summarizes efforts by participants in a June 2003 symposium, organized by AGB, the Association of Academic Health Centers, and the Association of American Medical Colleges, to answer four key questions:

- **What have university governing boards learned about the crisis in academic medicine and its strategic implications for institutional governance?**
- **What do university governing boards need to know in order to fulfill their governance responsibilities more effectively?**
- **How can a university ensure appropriate governance oversight of its academic health center?**
- **What more can AGB itself do to help meet the needs of governing boards with responsibility for academic health centers?**

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University governing board members must become versed in issues of risk that could have substantial consequences for the capital resources of the AHC—consequences that can very quickly jeopardize the community standing and financial integrity of the host university.

No board member can expect to become an expert in every field that has bearing on the assets of the university or its AHC. But a board can take steps to develop its collective knowledge beyond the expertise of any single member. To a considerable degree, the key to responsible governance lies in a board member's ability to understand high-level strategy and risk, to ask the right questions, and to seek the right advice from dependable sources when needed.

Varying Governance Structures. It is often said that "if you've seen one AHC, you've seen one AHC." The governance and management structures of nation's 143 AHCs are as diverse as the universities of which some 104 are part. In some cases a university will have a separate board of directors to oversee its AHC, while in other cases the AHC is one of several units under the auspices of academic affairs, and therefore under the purview of the president and governing board. The relationships and reporting lines among the dean of the school of medicine, deans of the other health profession schools, the hospital CEO, the university's central management, and the university's governing board carry the imprint of an institution's particular history and culture.

On many campuses, the AHC exists in a problematic relation to the rest of the university. The faculty and leadership of other schools and administrative units often fail to understand the special dynamics of medical education. While some of the AHC's teaching and research faculty may feel a strong affinity with other parts of the university, many of the clinician educators of the AHC conceive their professional goals and rewards differently from most other university faculty. Even among central administrators, some may fail to understand the significance of the AHC in the financial and academic life of the university. Notwithstanding these differences, it is incumbent on a board to maintain a clear perspective of the AHC's strategic importance within the context of its university.

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No single system of governance has proven to be superior on any absolute scale; the very diversity of decision-making structures among the nation's AHCs underscores the point that successful governance can take a variety of forms.

It is important that a board come to understand the university's governance structure in relation to its AHC—and possibly to explore new arrangements. In the era when AHCs were securely established as generators of major revenues for their universities, the existing governance structure may not have come into question or may have served the needs of the AHC and its host institution very well. It was satisfactory to have a board standing committee "oversee" the AHC and teaching hospital. Today, such dependence on a subset of the full board is no longer adequate.

The current environment is one in which AHCs, especially their teaching hospitals, are anything but assured in their ability to generate funds. The strategic risk and economic structure of the AHC, while bearing the particular stamp of the health-care environment, are nonetheless integrally related to many other aspects of the university's operations.

It is important that the issues confronting an AHC be understood and addressed in the context of other strategic challenges facing the university as a whole. A change in circumstances can send the ledger sheets of the AHC and its host university into the red in short order. More than ever before, an AHC's continued vitality depends on its ability to make strategic decisions in effective and timely ways. In some cases, gaining that ability may entail rethinking and even recasting the governance structure within an AHC and its home university.

Within any governance structure, one of the most important elements a board must consider is its own interaction with management. A key factor in the health of any institution is in fact the working relationship that exists between a board and its management. A university board must maintain a balance between providing support to management and becoming overly involved in carrying out the strategies that management pursues.

Financial crises in AHCs have occasionally drawn governing boards to extraordinary degrees of involvement in order to develop solutions. In the long run,

ACKNOWLEDGMENTS

This paper is one product of an initiative undertaken by the Association of Governing Boards of Universities and Colleges focusing on the issue of governing board responsibilities for academic health centers. AGB is working on this project in conjunction with the Association of Academic Health Centers and the Association of American Medical Colleges.

The impetus was a concern within AGB's board of directors about the growing challenges confronting university governing boards whose responsibilities include academic health centers. Two initial papers were commissioned. One is titled "Academic Health Centers: Current Status, Future Prospects," by David Blumenthal, M.D., MPP, director of the Institute for Health Policy Partners Healthcare System, and professor of Medicine and Health Care Policy, Harvard Medical School. The second is "Academic Health Centers: Organization, Governance and Fundamental Issues in a New Environment," by Roger J. Bulger, M.D., and Marian Osterweis, Ph.D., who are president and executive vice president, respectively, of the Association of Academic Health Centers.

These two papers helped provide a context for a special Academic Health Center Symposium convened by AGB in June 2003 in Arlington, Va., to discuss issues confronting university governing boards. The symposium included focused consideration of two specific cases in which a university and its AHC confronted major challenges leading to the formation of a business partnership with another health-care provider: Jack DeGioia, president of Georgetown University, described the circumstances that led ultimately to that institution's partnership with Medstar Health; and John Walda, chair of the AGB board and member of the Indiana University (IU) Foundation Board, related steps that led to IU's partnership with Methodist Hospital of Indianapolis to form Clarian Health.

This paper is a distillation of the most compelling insights and questions from the symposium. All three essays produced from this project are available at AGB's Web site at *www.agb.org*.

Financial support for the project was provided by generous contributions from the Commonwealth Fund and the Robert Wood Johnson Foundation.

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THE BOARD'S INTEREST LIES IN ENSURING THE APPROPRIATE LEVEL OF INSTITUTIONAL INVESTMENT TO ASSURE MANAGEMENT CAPACITY AND SKILL.

however, intense board involvement is neither desirable nor sustainable and must be brought back into balance. A board must distinguish between its responsibility for the fiduciary health of the institution—both fiscal integrity and academic quality—and its authority to direct specific strategies.

For the AHC as for the university as a whole, the responsibility for executing specific strategies lies ultimately with management; while the board empowers management to undertake those strategies, the board itself has neither the applied skills nor the responsibility to see them through. The board's interest lies more in ensuring the appropriate level of institutional investment to assure management capacity and skill. The following questions can help a board consider the university's governance structure in relation to its AHC:

- Is the existing governance structure well suited to meet the challenges and opportunities of the AHC within the university?

- Does the academic governance structure provide the AHC with the agility to adapt to a changing economic environment, develop a new programmatic emphasis, or modify existing academic directions?

- Do the reporting lines and flow of funds help or impede the AHC's ability to fulfill its mission?

- How clear is the delineation between the board and management?

- Has the board provided the leadership of the AHC and university with a clear institutional vision, without engaging in micro-management?

- Where does the opportunity and/or the need exist for simplifying the organization, developing more direct ties between those with fiduciary and management responsibility?

- In what light is the AHC regarded by the university as a whole? How well do academic leaders and faculty from other fields understand the AHC's missions in relation to those of the university itself?

- How do AHC academic issues fit into the faculty governance structure of the university? What kind of initiatives should the AHC have authority to take without full faculty approval?

Selecting and Supporting Management. Quite possibly there is no other example of a billion-dollar enterprise that has so many layers, so many overlapping lines of authority as commonly appear in an AHC. These intricate relationships reflect the complexity of AHCs themselves, but they give rise to questions of who is accountable to whom for what. Many professionals with extensive experience of these health centers perceive the need for closer ties of interaction and accountability between management and those with fiduciary responsibility for the AHC.

In conjunction with the university president, the board has critical responsibility in selecting the executive leadership of an AHC. As the challenges facing AHCs and their component parts become more complex and acute, the questions of what background and skills an executive should possess have taken on heightened importance.

Within the culture of these enterprises, management has traditionally risen from within the ranks of medical professionals themselves. A manager must clearly be perceived as a leader within the academic culture of the host university. Increasingly, however, he or she must be capable of maneuvering the AHC effectively within a wider framework of financial and strategic challenges. Another important consideration is that the health-care professions themselves are becoming more diverse in terms of gender, ethnicity, and national origin. In the years ahead, university boards will have a growing responsibility to ensure that the future leadership is not only competent in manage-

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rial terms, but also more reflective of both the range of professionals affiliated with the AHC and the range of populations served.

It is important that a board set clear financial goals for both the institutional chief executive and executive heading the AHC. Moreover, the university's trustees must ensure that the AHC has recourse to sufficient capital to support the strategic initiatives management undertakes. The board needs to know the strengths and weaknesses of the AHC itself and the steps that management is taking to realize a strategic vision. Finally, the board and management need a shared vision of the AHC's future and of how to reach its goals. Some questions the board might ask of itself in relation to the top management of the AHC:

- Do the qualifications traditionally used to select leaders in the health-care professions serve the needs of this AHC in the current environment?

- What skills and knowledge must an executive leader possess to manage the AHC, now and in the future? What combination of academic background and experience will fit the existing culture of the AHC and allow a manager to lead the organization through the strategic challenges it faces?

- How likely is a prospective leader to help a board in understanding the complex issues surrounding the AHC, and in providing guidance in reaching difficult decisions?

- How well does the leadership of the AHC reflect the demographics of the organization, and of the population served?

- What are the appropriate criteria to apply in measuring the effectiveness of management?

Assessing the External Environment. In some respects, the perfect storm has hit AHCs and their universities: they face declining reimbursements for the health care they provide in addition to increasing costs. Managed care organizations encourage their patients to seek health-care treatment from providers who offer services at lower prices. Because of the additional costs associated with their educational mission, teaching hospitals find it difficult to compete with those lower-priced providers.

A CENTRAL CHALLENGE IN THESE CASES IS TO ENSURE THAT THE TEACHING HOSPITAL'S STRATEGY FOR NAVIGATING THE EXTERNAL ENVIRONMENT IS NOT AT ODDS WITH THE STRATEGIES OF THE AHC AND THE UNIVERSITY ITSELF.

Another major factor in the external environment of AHCs is that virtually every state is now confronting serious budget deficits. These shortfalls have yielded direct cuts in appropriation to public universities and their AHCs. Medicare and Medicaid reimbursements have not kept pace with the costs that AHCs and their teaching hospitals have incurred in providing health care.

Through the course of the past three decades there have been dramatic changes in the marketplace for health-care delivery, and through the 1990s the rate and extent of change created a particularly turbulent environment for AHCs. Whereas in the mid-1990s the annual profitability margins of teaching hospitals averaged 5 to 6 percent, by 1999-2000 the average margin had declined to 1-2 percent. Teaching hospitals' payment-to-cost ratios also decreased dramatically in this period.

Regardless of its governance structure, an AHC that owns a hospital must regard that facility as a revenue engine; its operations constitute one principal means to produce the necessary capital to support the AHC's future development and mission fulfillment.

Ensuring the financial vitality of the hospital is an essential part of the long-range strategic plan of a university with an AHC. A teaching hospital within an AHC typically has its own board of directors, and a central challenge in these cases is to ensure that the hospital's strategy for navigating the external environment is not at odds with the strategies of the AHC and the university itself. The relative autonomy of a hospital's governing board may accord it greater agility

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in meeting fluctuations in health-care markets. Pains must be taken, however, to ensure that in surviving the business of health care the hospital does not compromise its service to the university's academic mission.

In the current environment for AHCs change can be swift and absolute, and new developments can transform what had once been a sound strategy into red ink almost without warning. A university board must work with management to monitor changes in that external environment, helping to ensure that the enterprise does not miss important signals on the horizon that could impact the future financial health of the AHC.

A university with an AHC must engage in a continual balancing act: on the one hand, it must maintain a clear commitment to supporting the academic mission of the AHC and the university of which it is part; at the same time it must remain continually attentive to changes in the markets for health-care delivery as well as for research funding.

BUILDING STRATEGIC PARTNERSHIPS IN

AGB's Academic Health Center Symposium included presentations of two cases in which a major university formed a partnership with another enterprise in order to better position itself in the fluctuating market for health-care delivery. One story concerned the partnership established between Georgetown University Hospital and MedStar Health. The other focused on the forging of an agreement between Indiana University's academic health center and Methodist Hospital in Indianapolis to form a new entity known as Clarian Health.

Both partnerships were responses to forces threatening the ability of academic health centers and their teaching hospitals to remain competitive—and to avert substantial financial losses that could affect the vitality of the teaching hospital, the academic health center, and ultimately the university itself.

While their circumstances differ somewhat, the two stories share common elements. Both involve actions taken in response to a changing external landscape:

- A significant decline in the number of direct reimbursements for services provided in the university's hospital and clinics;
- An increase in the number of managed care organizations imposing limits on payments provided for services, effectively steering patients from the university AHC to lower-cost providers;
- The growth of powerful physician provider groups and specialty hospitals targeting the most lucrative parts of the market; and
- Rising costs for the delivery of health care, particularly in the context of an educational mission.

Jack DeGioia, now president of Georgetown University, was executive vice president of the institution during the 1990s. He recounts that during these years Georgetown's academic health center was investing heavily in its biomedical research capacity, particularly in cancer research. The costs of this development were to be met in part from the margins generated by the AHC's clinical enterprise. During this period Georgetown was also pursuing a business strategy of vertical integration—through the acquisition of clinics and provider practice groups in the greater Washington, D.C., area—as a means of securing its market share in the delivery of health care.

What became clear, DeGioia observes, was that these choices had resulted in the university taking on substantially increased financial risk. In 1997, Georgetown's AHC incurred an operating loss of $57 million, followed by a loss of $67 million in 1998, and of $85 million in 1999. The situation threatened to deplete the capital assets the university had built up over many years. Ultimately, the university undertook an intensive search for a partner organization—an effort that required a significantly expanded and different set of skills from Georgetown's board. One board member in particular came to play a key role in negotiating the deal with MedStar Health. The new arrangement succeeded in stabilizing both the hospital's and university's operating losses and restoring financial equilibrium to its AHC.

In the mid-1990s the board of Indiana University (IU) was taking careful stock of the changes occurring in health care. John Walda, currently a member of IU's University Foundation, was serving as chair of IU's board during this period. He recalls that on the basis of developments occurring in other parts of the country, the board saw the clear potential for losing a major share of the

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Questions trustees might usefully ask include:

• Does the board collectively have enough experience to address the range and complexity of issues surrounding the AHC in relation to the missions it serves? Is the board's membership and structure properly situated to monitor and fulfill its responsibility for ensuring the financial well-being of the AHC?

• Do the board and management have enough information and support to carry out their responsibilities in effective ways? What kinds of support systems will allow trustees and chief executives to be most effective without becoming overloaded or intrusive?

• How can the university minimize its exposure to major financial liabilities while at the same time sustaining a workable AHC as an integral part of the university's mission?

ACADEMIC HEALTH CENTERS: TWO CASES

patient revenue necessary to sustain the university's hospital and its AHC.

The university began a proactive search for a partner organization to help it survive what it foresaw as an environment of decreased revenues due to the advent of managed care. IU's board and management sought a partnership that would confer the advantages of major cost consolidation, a strengthened market position, an enhanced environment for the education of health-care professionals, and increased bargaining strength in negotiations with managed care organizations. In addition, IU sought a partner with core values that were conducive to the mission of educating future health-care professionals. Ultimately the University found such a partner in Methodist Hospital of Indianapolis; the two organizations engaged in negotiations that led to the establishment of a new hospital corporation ultimately known as Clarian Health.

The board of this new organization includes 11 members, including a representative from IU and another from Methodist Hospital, one from the affiliated IU Medical Group, and a fourth from the Methodist Medical Group. The Clarian board has the independence and flexibility that allow it to respond quickly to changes in health-care markets. As with the Georgetown case, the creation of a new organization called on certain members of the Indiana University board and executive leadership to devote considerable amounts of time and skills to completing the agreements. Among the most difficult issues was the question of how to handle university faculty members with tenure who would now work with private employees of the new organization.

Reflecting on their separate experiences of leading a university and its AHC through a major set of transitions, DeGioia and Walda offer very similar lessons for members of university boards with responsibility for an AHC.

• *Know the business of the enterprise.* Understand that an AHC's success in fulfilling its mission is a direct function of its financial well-being. The board collectively must have a clear understanding of the cost and the financial risk AHCs incur in educating future health-care professionals.

• *Understand the problem you're trying to solve.* When faced with a specific challenge to the AHC's revenue and capital assets, the board must have an explicit theory of the case. It must be prepared to act deliberately in conjunction with management to respond to a crisis at hand. Finally, the board must ensure that there is sufficient capital to support the business strategy.

• *Understand the responsibilities that are required to solve the problem.* Know that a major transformation—such as the formation of a new business partnership—may well require that certain board members temporarily take on expanded duties that draw extensively upon their professional skill and expertise.

• *Commit to ongoing development of the board itself.* Health care is a complex and high-stakes enterprise; to make responsible decisions, a board must invest deliberately in its own development. The board must come to know the strengths and weaknesses of the organization; it must develop a shared vision with management of the AHC's goals and of how to achieve them. Finally, a board must cultivate relations with other organizations and experts that can help its members understand the challenges confronting the AHC and the strategic options available to it.

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HOWEVER GREAT THE INTRINSIC VALUE OF A PARTICULAR SOCIETAL MISSION, THE FULFILLMENT OF THAT MISSION REQUIRES MONEY.

- Do the board and management have a contingency plan for addressing unforeseen events that could have major financial consequences?

- What proportion of the AHC's patient revenue is fee-for-service? What proportion is covered through managed care? Through Medicare and Medicaid? What proportion of the health care the AHC delivers is unreimbursed?

- What sources of revenue to the AHC are most at risk as a result of changes in the external environment? Are there trends or developments that could jeopardize the financial circumstances of the AHC?

- Do the hospital and clinical services command enough market share to have bargaining power with managed care providers?

- Who are the principal competitors for the AHC's market share? How has the distribution of market share changed in the past two years? Has the AHC's position strengthened or weakened?

- What strategies is the competition pursuing that could impact the AHC's market position in the future?

- What other changes in the external conditions would threaten the long-term financial health of the AHC?

Board Understanding of the Field. An AHC is in many respects a microcosm of its host university. It encompasses three very different, though closely related missions: educating health-care professionals, conducting medical research, and providing clinical care.

Succeeding in each of these missions may entail different kinds of organizational structures and different business strategies within the AHC. In addition to supporting the different missions of the AHC, a board must also understand the factors, including external competition, that pose a challenge to the fulfillment of each mission. Exercising responsible stewardship entails that a board recognize the most promising opportunities for revenue generation as well as the risks associated with fulfillment of the AHC's mission.

It is incumbent on a board to understand the business case for each of the AHC's missions. In the course of gaining this perspective, the board will need to support management's strategies for ensuring that each mission achieves its purposes without jeopardizing the financial health of the AHC and its host university.

While some missions of an AHC have a clear potential to generate revenue in excess of their costs, others do not. For this reason an AHC must determine how and where to create cross-subsidies among its missions and activities. The most common direction of these subsidies has traditionally been from the clinical enterprise to the education enterprise.

Not everyone in an AHC—or in the university as a whole—understands the flow of dollars among the different missions of an AHC. Part of a board's responsibility is to gain a clear perspective on the directions and extent of those subsidies. A key issue that confronts both the management and board of universities is how to finance the education of health-care professionals as clinical practices generate less capital in relation to their own costs and become less capable of subsidizing the AHC's education mission.

A telling observation sometimes heard among institutions dedicated to the fulfillment of public purposes is: "No margin, no mission." However great the intrinsic value of a particular societal mission, the fulfillment of that mission requires money. If the capital invested in a given mission exceeds the revenue it attracts, the institution must consider the social value and impact of that mission in relation to the subsidies it requires: what sources—within the AHC, the university, or external agencies—can provide the revenue to sustain that mission?

For all kinds of institutions, and particularly universities with AHCs, the alignment of money with

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mission is a fundamental concern of board members. A university board must combine sensitivity and practical judgment in balancing the social values and the business case of the different missions an AHC pursues. Some questions a board might consider in attaining this balance:

- Has the board seen and understood the business case for each of the AHC's missions? Is each model well-suited to the fulfillment of the larger strategic plan of the AHC and the university?

- Which assumptions of the business model fit the current environment, and which do not? What are the signs that the current strategies employed by the AHC are reaching their goals?

- Which elements of the AHC's mission currently produce the greatest margins?

- What are the most promising sources of capital that the AHC will need in order to achieve its strategic vision? Where is the potential for significant revenue enhancement?

- To what extent are there cross-subsidies among different programs and departments of the AHC? Where and how do those subsidies flow, and what is the impact? Is the AHC in a position of needing to draw on the university's working capital to subsidize its operations?

- Where does the AHC fit in the overall picture of acquisition of university resources, the allocation of costs, and the ultimate commitment of resources?

The Value of Partnerships. Through the past decade in particular, changes in the economic environment of health care have led AHCs to undertake major strategic initiatives, often at substantial risk, for the purpose of gaining heightened stability and strength in the market for health care.

No single strategy describes the maneuvers AHCs and their universities have taken to maintain their course through this turbulence. Some AHCs have aggressively sought to strengthen their position within a region by building extended networks through mergers or acquisitions that include hospitals, clinical practices, physicians, nursing homes, and health plans. Other AHCs have pursued the opposite strategy of selling teaching hospitals, dissolving direct financial ties between themselves and clinical practices and faculty group practices. Making responsible judgments about what strategy is appropriate for a given AHC requires that a board have a certain grounding in the factors that could affect a strategy's ultimate success.

THE BOARD HAS A RESPONSIBILITY TO ENSURE THAT THE NEW PARTNERSHIP DOES NOT UNDERMINE THE AHC'S ABILITY TO ACHIEVE ITS ACADEMIC MISSION.

One of the strategies AHCs have pursued in recent years is to enter into partnership with another entity—a corporate health-care provider or clinical practice organization within the region. In undertaking a major partnership with another entity, the issues to resolve are as complex as the two organizations involved. In some cases, the AHC may engage in partnership as a proactive move to gain a more advantageous position in the evolving market. In other cases, partnership with another entity may be a reactive step to avert substantial losses the AHC is incurring in its hospital and clinical practices operations.

In either case, forging a different corporate identity yields a fundamental change of status of the AHC. Taking a step of this sort requires that both management and board understand the alignments of responsibilities as well as the flow of funds within the organization. Most important, the board has a responsibility to ensure that the new configuration does not undermine the AHC's ability to achieve its academic mission.

Regardless of the circumstances prompting the consideration of a new partnership, an AHC must consider several factors in such a gambit. The AHC's ranks of professionals include science faculty with tenure in addition to clinical faculty; hence the ques-

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tion of how academic tenure will be handled in a partnership entity is likely to accentuate the differences between an academic and non-academic culture.

Entering into a partnership will likely require the sustained attention of a core set of board members as well as the chief executives of the AHC and the host university. Clinical partnerships do not remove risk from the AHC equation; indeed, they present a different set of risks that require close monitoring, especially where the economic stability of the AHC is dependent on the fiscal health of the partner. Some of the major questions that the board as a whole should bear in mind:

- Does the partner have the same philosophy concerning the delivery of health care? Does it share the AHC 's commitment to serving the public? Does the partner ascribe the same importance to the educational mission as the university does?

- What prospective benefits would result from a partnership with another entity in terms of...

  - major cost consolidation?
  - the achievement of an advantageous market position?
  - an enhanced environment for medical education?
  - increased bargaining strength in dealing with managed care?
  - capital sharing?
  - risk sharing?

- How will management meet the different expectations of academic faculty with tenure and clinicians accustomed to competing in the market for health care?

A Time of Transition. In the past, AHCs have by and large been driven by an academic culture. The national standing and prestige of a given center has been measured largely by the success of individual departments that have attracted substantial research funding as well as clinical groups that have built and sustained a strong patient base. AHCs have for the most part prospered from the entrepreneurial drive and strategy of particular groups; in general they have not advanced on the basis of a comprehensive institutional plan.

One result of this history is that some AHCs have come to seem less than efficient-and even dysfunctional-in their collective operations. In many of these centers, the lack of sophisticated and contemporary management skills among the executive leaders, combined with the lack of sophisticated technology to support management information systems, have become warning signs of a troublesome future. It is vital that the university board and the executive leadership monitor the well-being of the AHC itself-as a whole, not just in its parts. Moreover, the board and leadership must have strategies at hand and skills to intervene if the vital signs should begin to fail.

A central question that a university board must ask is to what degree, and in what ways, the AHC is advancing from a model of largely independent agents to an institutional model with a unified, strategic vision for the future. Increasingly, it will be necessary for AHCs to become leveraged institutions, bringing into play forces that the AHC or the university cannot directly control. Accordingly, a key question that boards and chief executives must engage is how these AHCs should be governed as time and circumstances yield changes that can lead a university very rapidly into red ink.

It may be that in ten years AHCs will be governed differently, because many of the assumptions behind the current models will no longer pertain. The years ahead will be a time of transition for AHCs. The decisions that university boards make will be extremely important during this period; in addition to helping their AHCs through the hurdles of the moment, trustees must help these university health centers evolve to positions that allow them to ensure continued quality in fulfilling their missions of medical education, research, and the delivery of clinical care-for the well-being of individual patients and society as a whole.

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